Joint area review

Haringey Children's Services Authority Area

Review of services for children and young people, with particular reference to safeguarding.

Ofsted
Healthcare Commission
HM Inspectorate of Constabulary

Age group: All

Published:

Reference no:

Contents

Introduction

1. The inspection was conducted using the arrangements for joint area reviews as required under section 20 of the Children Act 2004. It is a special joint area review, commissioned in November 2008 by the Secretary of State for Children, Schools and Families. It was commissioned following the death of Baby P in Haringey and the subsequent findings of the serious case review, which examined the circumstances of the baby's death and the role of each of the services involved with the family.

2. The remit for this inspection was to undertake an urgent and thorough inspection of the quality of practice and management of key services which contribute to the effective safeguarding of children in the local area. In doing this, the inspection team was required to ensure rigorous scrutiny of the quality of practice and decision-making by front line workers and their managers, including the effectiveness of management practice and performance management systems in all relevant agencies.

3. The inspection was undertaken in a much shorter timeframe than is usual in joint area reviews but nevertheless used the approach set out in the *'Framework for the inspection of children's services'*[1] as the basis for inspection. The inspection evaluates the contribution made by relevant services in the local area to ensuring that children and young people are safe.

4. The inspection commenced on 13 November 2008 and was completed by 26 November 2008. It was carried out by a multi-disciplinary team of seven inspectors from Ofsted, the Healthcare Commission and Her Majesty's Inspectorate of Constabulary.

5. Evidence gathered included: observations of social care duty room practice; a review of case files for children and young people receiving support from a number of local agencies, including those relating to Baby P; discussions with elected members of the local authority and managers from these agencies; service users, including children and young people, and community representatives.

6. The inspection also considered a range of existing evidence including:

- a review of the children and young people's plan
- performance data
- information from the inspection of local settings, such as schools and day care provision

[1] Every Child Matters: framework for the inspection of children's services, Ofsted, July 2005; *available from www.ofsted.gov.uk/publications.*

- briefings from staff within inspectorates, commissions and other public bodies in contact with local providers
- the serious case review relating to Baby P
- the evaluation of the serious case review undertaken by Ofsted in accordance with *'Working Together To Safeguard Children'*, 2006.

Summary judgement

This inspection has identified a number of serious concerns in relation to safeguarding of children and young people in Haringey. The contribution of local services to improving outcomes for children and young people at risk or requiring safeguarding is inadequate and needs urgent and sustained attention.

Main findings

7. The main findings of this inspection, described below, point to significant weakness in safeguarding and child protection arrangements in Haringey. They also show that the arrangements for the leadership and management of safeguarding by the local authority and partner agencies in Haringey are inadequate.

   - There is insufficient strategic leadership and management oversight of safeguarding of children and young people from Haringey by elected members, senior officers and others within the strategic partnership.

   - There is a managerial failure to ensure full compliance with some requirements of the inquiry into the death of Victoria Climbie, such as the lack of written feedback to those making referrals to social care services.

   - The local safeguarding children board (LSCB) fails to provide sufficient challenge to its member agencies. This is further compounded by the lack of an independent chairperson.

   - Social care, health and police authorities do not communicate and collaborate routinely and consistently to ensure effective assessment, planning and review of cases of vulnerable children and young people.

   - Too often assessments of children and young people, in all agencies, fail to identify those who are at immediate risk of harm and to address their needs.

   - The quality of front line practice across all agencies is inconsistent and not effectively monitored by line managers.

- Child protection plans are generally poor.
- Arrangements for scrutinising performance across the council and the partnership are insufficiently developed and fail to provide systematic support and appropriate challenge to both managers and practitioners.
- The standard of record keeping on case files across all agencies is inconsistent and often poor.
- There is too much reliance on quantitative data to measure social care, health, and police performance, without sufficiently robust analysis of the underlying quality of service provision and practice.

Recommendations

The Department for Children, Schools and Families should:

- provide immediate appropriate support and challenge to the local authority to ensure that comprehensive and effective safeguarding arrangements for children and young people are established.

The Local Authority, working with its partners and in particular health and the police, should:

- improve governance of safeguarding arrangements. In particular, they should ensure full compliance with the guidance contained within *'Working Together to Safeguard Children' 2006* and embed the London protocol for inter-agency working to improve outcomes for children and young people.
- establish more secure assessment and earlier intervention strategies which ensure that, in all cases where concerns about children are identified, agencies can intervene and assess risks of significant harm to children in a timely manner.
- establish more systematic monitoring of the quality of practice.
- ensure that managers and staff at all levels are accountable for casework decisions, and that they draw as necessary on the expertise of partner agencies to inform the decision making process.
- take steps to integrate individual service processes and systems across all agencies more effectively, so that all children and young people are safeguarded.

- assure the competence of leadership and management in all areas of children's services and develop clear and effective accountability structures.

- establish rigorous arrangements for management of performance across all agencies, which ensure that the quality of practice is evaluated and reported regularly and reliably, and that accountability for each action is defined and monitored.

- make explicit to all staff and elected members the expectations and standards required of front line child protection practice.

- establish rigorous procedures to audit and monitor the quality of case files across all partner agencies and ensure processes are in place to deliver improvement.

- establish clear procedures and protocols for communication and collaboration between social care, health and police services to support safeguarding of children, and ensure that these are adhered to.

- assure the competence of service and team managers in conducting rigorous and evaluative supervision and monitoring of safeguarding practice.

- appoint an independent chairperson to the local safeguarding children board (LSCB).

Whilst not a mandatory requirement, it would be good practice for the Local Authority to:

- ensure that all elected members have CRB checks.

- ensure that all elected members undertake safeguarding training.

1. Safeguarding

Serious case review – Baby P

8. Local safeguarding children boards undertake a serious case review when a child has died or has been seriously injured or harmed and abuse is known or suspected to have been a factor. The process is defined by the guidance in *'Working Together to Safeguard Children'* (Chapter 8). Local agencies are asked to decide whether there are any lessons to be learned about the ways in which they worked together to safeguard and promote the welfare of the child.

9. During the period 2006 to 2008 one serious case review was completed by Haringey safeguarding children board. This relates to Baby P. A second, unrelated, serious case review is in process, but was slow to begin.

10. Baby P, a 17 month old boy, died on 3 August 2007 from severe injuries which were inflicted whilst he was in the care of his mother, her partner and a lodger in the household. On 11 November 2008 at the Old Bailey two men were found guilty of causing or allowing the death of a child or vulnerable person. The mother had already pleaded guilty to the same charge. Baby P had been subject to a child protection plan from 22 December 2006, following concerns that he had been abused and neglected. He was still subject to this plan when he died.

11. Ofsted has judged the quality of the serious case review relating to Baby P to be inadequate. The terms of reference are insufficiently comprehensive, lack clarity, and were not finalised until 12 December 2007. This was four months after the serious case review process began, and when the writing of the individual management reviews by the relevant agencies had already been completed. This resulted in some important aspects not being adequately considered, such as the capacity of front line services, the effectiveness of provision for other children in the family, and the reasons why agencies failed to discover the two men living in the household. There was insufficient independence of the serious case review panel; the panel was chaired by the director of the children and young people's service, who also chairs the local safeguarding children board.

12. The quality of the nine individual management reviews submitted is variable. The reviews submitted by Whittington Hospital NHS Trust, the Metropolitan Police and Haringey Legal Services are judged good. The review submitted by the Family Welfare Association is judged adequate. However, inadequate individual management reviews were provided by the Haringey children's social care service, Haringey schools, the North Middlesex University Hospital/Great Ormond Hospital NHS Trust, Haringey Teaching Primary Care Trust, Haringey Strategic and Community Housing Prevention and Options Team. The individual management reviews provided by social care services and

the primary care trust lack rigour in their analysis and thus significantly undermine the integrity of the serious case review. The overview report does not look at the capacity of front line services to deliver what was required of them, or the quality of management oversight and support. As a result, the serious case review misses important opportunities to ensure lessons are learned. Key actions required in order to improve safeguarding are not fully identified.

2. Practice relating to safeguarding

Effectiveness of arrangements to identify and respond to concerns

13. The thresholds for accessing social care services and the process for receiving referrals are clear. However, staff from a range of partner agencies express concern about inconsistencies in the application of the thresholds for access to children in need and child protection services.

14. Following referral, arrangements for gathering information from relevant and involved parties are generally poor. The requirement that referrers be informed in writing of action taken in response to the referral is not routinely met.

15. All children's social care cases are allocated a social worker. However, workloads are heavy and some staff report that they are unable to action all cases effectively as a result. Some allocations of cases within social care services are made electronically and without discussion with social workers. This does not ensure there is discussion between the manager and social worker about what actions are to be taken.

Quality of recording, assessment and child protection planning

16. Case file recording for individual children and young people is inadequate. There is insufficient evidence of managerial oversight and decision-making on case records in children's social care services, police and health services. There is also limited evidence of thorough, analytical and reflective supervision to ensure individual casework is carried out effectively.

17. Police and health service files are often poorly organised and the process and planning of individual cases is difficult to follow. Health services' files include hand-written notes which are sometimes illegible and do not identify the author. The standard of record-keeping in the health records of looked after children and young people is poor and some entries are inaccurate.

18. Not all children's social care files have a chronology of the individual case. Police files also do not establish clear chronologies of events and it is difficult to decipher the key points at which decisions are made. The rank of the police officers involved is not always clearly stated, making it difficult to determine the level of supervisor involvement in the case.

19. While some files demonstrate that children and young people are seen and spoken to and their views taken into account, this is not consistently demonstrated in assessments. Files of children and young people subject to child protection plans and those of looked after children and young people state whether a child is seen alone. However, where the child has not been seen alone, there is limited evidence of managers addressing the reasons for this and enabling the child's voice to be heard.

20. There are frequent unacceptable and extreme delays in distributing to partner agencies the minutes of key meetings, such as child protection conferences, core groups and statutory reviews of looked after children and young people. This means that information and follow-up action required is not effectively and promptly communicated to all agencies involved with the child and his/her family.

21. Assessment and care planning are poor overall. The repeated failure to take proper account of historical concerns places children and young people at risk. Information from other agencies is not always used to inform assessments of children and young people, leading to weak analysis and understanding of the risks to the safety of the child. Managers in all agencies are aware of the poor quality of assessments. However, there is no identifiable activity to address these serious deficiencies.

22. The quality of health assessments for looked after children and young people is poor. There is insufficient guidance for and oversight of the work of general practitioners who undertake the majority of assessments.

23. The quality of assessments of risk to children and young people contained within police notifications of incidents of domestic violence is too variable. All such incidents where children are known to be in the household are notified to children's social care on a dedicated police system. However, they are not all sent in a timely way.

24. The use of the common assessment framework as a tool for multi-agency assessment is not universally understood or effectively implemented by staff across agencies, despite them having been trained. While the data show apparent good progress with assessments completed for over 800 children and young people, this figure masks the fact that most are not multi-agency assessments. The process is used primarily by agencies as a referral for additional individual services. Implementation of the common assessment framework has not been evaluated.

Effectiveness of inter-agency child protection

25. Inter-agency cooperation in child protection work is inadequate. The majority of child protection strategy discussions on files read during the inspection only involve staff from children's social care services and the police. While this may be pragmatic in urgent cases, there is limited evidence of consideration of the need for a subsequent strategy review meeting involving other relevant agencies, such as health or schools.

26. The police referral desk structure ensures that managers are involved at the child protection referral stage and that they participate in telephone strategy discussions. However, managers are not normally involved in subsequent strategy meetings. There is evidence of inconsistency in management decision making, primarily in relation to those cases initially assessed as low risk and/or where limited information is available. There is no definable threshold for when a minor neglectful act becomes a criminal offence and each single incident must be examined in the context of other acts or omissions. The possibility of a criminal offence, and the need for an initial criminal investigation, is not always considered.

27. When a referral is made to the police child abuse investigation team, a number of checks are made to identify any previously known information about the child and family. There is good evidence that the policy about making these checks is being adhered to. However, these checks do not currently routinely include those names on the violent and sexual offender register (ViSOR). It is of concern that relevant information from ViSOR is not currently obtained to inform decision making and risk assessment.

28. There is clarity amongst police practitioners about the circumstances in which a request is made for the medical examination of children in both potential physical and sexual abuse cases. However, although the police generally attend examinations in sexual abuse cases, they do not regularly attend examinations in cases of suspected physical abuse.

29. Some accident and emergency services staff at North Middlesex and Whittington Hospitals are insufficiently clear about how to access up to date information regarding whether a child is subject to a child protection plan. These services do not have online access to the list of all children with such plans and rely on a hard copy list, which is distributed weekly. Some staff are not aware that telephone access to the updated list is possible. Although the London strategic health authority has advised that all children and young people who attend accident and emergency services should be checked against the list of those subject to child protection plans, this does not always happen.

30. Child protection plans are generally poor. There is insufficient involvement of key staff from health and other agencies to ensure that the plans take full account of the child's needs. In most cases children are visited by social workers within expected timescales. However, in many cases there is a lack of clarity about what needs to be done, and by whom, to reduce identified risk

and there is little evidence of the impact on improving the safety or welfare of the child. Agencies are generally working in isolation from one another and there is evidence of a lack of effective co-ordination to ensure the work is appropriately focussed.

31. In some cases, children and young people are not consulted in order to establish their views about their child protection plan. While attendance at child protection conferences by children, young people, parents, carers, is monitored, the information is not collated and analysed by the local safeguarding children board, which limits its oversight and impedes improvement of the process.

32. Attendance by professionals who are working with the child and his/her family at child protection core group meetings is also variable. Some meetings are cancelled due to non-attendance by key agency representatives, while others go ahead without sufficient attendance by members. This limits the opportunities to take account of full information when making decisions and recommendations for the future, and for ensuring that the child protection plan is on track.

33. Guidance to staff about placement of children with family or friends is contained within the London child protection procedures. This focuses on situations where children and young people may be accommodated or placed as an emergency placement while carers are being fully assessed. Staff expressed concern to the inspectors about the quality of some foster families and the lack of robust arrangements to ensure that the views of placing social workers are sought to inform the annual foster carer review.

34. There are indications that police child abuse investigation teams are not always receiving required information in domestic violence cases. Issues of communication are identified by previous Her Majesty's Inspectorate of Constabulary inspections. Measures have been taken to improve communication but it is too early to assess the impact.

3. Service management

Leadership and management of safeguarding arrangements by the local authority and partner agencies in Haringey are inadequate.

Effectiveness of governance arrangements

35. The relationship, accountabilities and lines of communication between the children and young people's strategic partnership board, the local safeguarding children board, and the children and young people's consultative committee are not sufficiently clearly defined in their terms of reference. Not all members of these groups are clear about their remit or how their work links with, or overlaps, with the work of other groups. There is insufficient robust challenge

to procedures, practice and performance evidenced in the records of the meetings.

36. The work of the local safeguarding children board is insufficiently robust. Whilst it maintains a focus on the wider safeguarding agenda, the impact of this work on making life safer and more secure for children and young people is not well evidenced. The board has taken a lead in identifying key safeguarding issues of concern to children, young people and their families and has worked across agencies to tackle these issues. However, multi-agency attendance at board meetings is variable, the follow-up of issues and agreed actions is not sufficiently rigorous, insufficient attention is paid to the quality of individual case work practice and board members do not provide sufficient independent challenge.

37. Current management arrangements within the council and across the partnership do not facilitate sufficient independent challenge on safeguarding matters. The local safeguarding children board is chaired by the director of the children and young people's service. The management arrangements for independent reviewing officers, with senior management responsibility resting with the deputy director of the children and young people's service, are insufficiently independent of operational line management in social care.

38. There is limited evidence of the priorities and policies of the children and young people's plan being robustly put into practice on the ground. Also, the priorities are not supported by effective planning and evaluation. For example, the people workforce plan was developed in isolation from the children and young people's plan. There are few examples of integrated working arrangements being based on shared aims and common understandings of practice and management expectations. There are some good policies, but they are often not acted upon, such as the social care supervision policy, with the result that outcomes for children and young people are seriously compromised.

39. Corporate parenting arrangements are underdeveloped and there is currently a lack of shared responsibility across the council for this function. While there is a strongly articulated commitment about support for looked after children and care leavers, there is no overarching corporate parenting protocol and plan. Some elected members have undertaken relevant training and acknowledge that this should be extended to all councillors. However, other elected members interviewed reported that they have not received child protection or safeguarding training. The contribution of looked after children and young people to the children and young people's consultative committee is valued and strategies to further engage young people are being sought.

Effectiveness of performance management

40. Performance management arrangements across agencies are insufficiently robust. The reliance on national and local performance indicators is too great and does not enable understanding of the quality and effectiveness of service provision on the ground. Insufficient attention has been given to evaluating the

quality of front line practice and quantifying the impact of services upon children. There has been a failure to use the outcomes from qualitative audit activity to critically self evaluate and to report on the actual outcomes for children and young people. The partnership does not use performance indicators to question and challenge underlying issues about the quality of front line practice.

41. The council provides regular reports to managers, the local safeguarding children board, the children and young people's consultative committee and the children and young people's strategic partnership on social care performance. However, the accompanying commentary is descriptive and lacks robust critical analysis.

43. An audit report commissioned by the council in late 2007 highlighted specific weaknesses in child protection practice. Two further independent audits and additional internal audits of front line social work practice have been carried out since that time. These also identified weaknesses and inconsistencies in practice and multi-agency working. However, the management reports on these audits, which were presented to elected members, did not accurately reflect the significance and implications of the unsatisfactory practice for the safety of children and were not supported by solid action plans.

44. Social care service management data collected by the council are unreliable. The performance indicator data regarding timeliness of initial and core assessments suggest that this is good. However, a number of files seen during the inspection show that the assessments are 'counted' as complete although the documentation is incomplete on file. In addition, cases of families with more than one child do not always have separate files opened for siblings. This means that the true number of children allocated to a social worker is not accurately counted. Cases identified for closure are not always closed promptly.

45. The primary care trust has developed a performance management process with quarterly meetings to monitor its service agreements with other health agencies. Trusts provide data to the primary care trust to monitor the service level agreement, as well as informing board meetings and service managers. However, staff consider that child and adolescent mental health services (CAMHS) data quality need improvement. The data indicate trends or issues at service level and is challenged by the primary care trust, with examples of changes being made as a result of the data. The performance management arrangements provided by the strategic health authority are not always effective. Trusts routinely report serious untoward incidents, which are reviewed by the strategic health authority safeguarding lead. However, the systems and processes are not embedded and trusts do not always respond positively to strategic health authority requests for information or meetings.

46. The police specialist crime directorate structure provides for clear accountability and the accountability framework is also available on the force intranet. Performance across the directorate is also monitored centrally and monthly management reports are produced. There is also an inspection and audit regime, which is currently under review. However, the capture and dissemination of organisational learning and knowledge management is not systematic and relies on individual leaders taking responsibility for circulating good practice and learning from debriefing.

47. Individual case files in all agencies show too little evidence of management oversight and decision-making. A high priority is given to ensuring regular supervision of staff, and most staff across all services report that they receive regular supervision and feel well supported by their line managers. However, records of case discussions are not routinely placed on service users' files. This is unacceptable.

Workforce development and safe recruitment practice

49. All agencies meet the minimum requirements for criminal record bureau (CRB) checks on staff. The council human resources files seen during the inspection show that appropriate employment and identity checks are made. Health and social care services have a process whereby staff can be appointed prior to the receipt of CRB checks. While the health process ensures that supervision is given to such staff until the check is complete, the process in social care services is less clear, which is not good practice. Not all elected members have had CRB checks.

50. The high turnover of qualified social workers in some social care teams has resulted in heavy reliance on agency staff, who make up 51 of 121 established social worker posts. This results in lack of continuity for children and their families and of care planning. Action has been taken to attract staff, including an increase in pay scales and a graduate trainee scheme. Currently there are four unfilled social work posts. Some social workers have heavy caseloads, exacerbated by the need for experienced staff to complete unfinished work for those staff who leave. Although a transfer protocol is in place to define when a case should transfer to long term social care teams, in practice there can be difficulty making timely transfers due to capacity issues within teams.

51. Previous longstanding severe shortages of staff in community nursing services resulted in a reduction of preventative health care available to children and young people in the borough. Ten additional health visitor posts have recently been created and recruitment to these posts is underway. Staff express concern that the level of staffing in child and adolescent mental health services is insufficient to meet the demand.

52. The direct involvement of police supervisors in strategy discussions and/or meetings is unsystematic, with the evidence suggesting that these are generally undertaken by investigating officers. Detective Sergeants within the child abuse investigation team also carry their own investigative workload. Previous

HMIC inspections have identified the need to ensure that supervisors have the capacity to balance effectively their day-to-day supervisory commitments with specific responsibilities, such as strategy discussions, and their own investigative workload. Serious crime directorate resources were reviewed in 2006 and, as a result, the Haringey child abuse investigation team has been allocated additional resources, effectively doubling the number of Detective Constable investigators. However, the child abuse investigation team has been carrying a supervisory vacancy for some time, which has resulted in gaps in supervision on the ground. The police conference liaison officer role is critical within the child abuse investigation team in relation to the police contribution to child protection conferences, including provision of information and attendance. However, the current level of staffing is insufficient.

53. The existing social care electronic recording system operated by the council lacks sufficient flexibility and, although this impedes effective practice by social workers, there has been insufficient priority given to resolving this issue by managers.

54. Staff in schools report that the quality of child protection training is good, with very useful advice and support provided by Child Protection advisers.

55. Police training provision is compliant with the Victoria Climbie recommendations. All serious crime directorate officers undertaking an investigative role are expected to complete the initial crime investigator's development programme. Investigators also complete specialist child abuse investigation training. There is, however, currently no role-related training for referral desk duties, which are carried out by Detective Sergeants, and the view is that the current general training available is inadequate to fully equip supervisors for this role. Additionally, there is currently insufficient attention paid to the planning and timing of training for new post-holders to ensure that it is provided promptly.

56. Child protection training is mandatory for all health services staff. The training strategy, launched in 2007/08, is comprehensive, with training at different levels identified in staff job descriptions. Information on numbers attending is submitted to the primary care trust board.

57. Police policy and standard operating procedures have been available on the intranet for approximately three years and have been updated in the last six months, although there have been no significant changes. All staff are aware of how and where to access information and guidance. National police guidance has also been fully implemented and there is a dedicated policy portfolio led by a superintendent responsible for ensuring that policy is updated and refreshed as necessary. A reserve desk also provides out-of-hours advice to staff engaged in child protection matters.

Annex A

Context

1. Haringey is an ethnically diverse outer-London borough situated to the north of central London. Of its population of 224,700 people, nearly half come from minority ethnic backgrounds and around one quarter are under the age of 20.

2. The population has grown by 8.6% since 1991 and is projected to grow by a further 3.7% by 2016 to 233,100. The population has high turnover and includes a significant number of refugees and asylum seekers. Over 160 languages are spoken by children and young people in the borough.

3. Long-term unemployment is twice the national rate and almost twice the London rate; in October 2007, 6,720 of Haringey residents were claiming job seeker's allowance, a rate of 4.3% compared to the London average of 2.7% and the national average of 2.1%. Northumberland Park ward has the highest unemployment rate of all London wards at 16.7%, almost eight times the national rate. It is estimated that 21% of households in Haringey are living in unsuitable accommodation. The borough has high levels of crime, although this has reduced overall, in contrast to the London trend.

4. There are approximately 48,965 children and young people under the age of 20 living in the borough, with three-quarters from minority ethnic communities. Of these, 191 are children with a child protection plan, 450 children are in the care of the local authority, 230 are unaccompanied asylum-seeking children with 48 of those in care, 723 are young carers and 403 children and young people are registered with the youth offending team. The percentage of children and young people eligible for free school meals is over twice the national average (32% compared with 15%) but with a vast differences across the borough, for example, 7.8% in Alexandra ward compared with 50.7% in White Hart Lane ward.

5. The Haringey strategic partnership was set up formally in April 2002. The children and young people's partnership board, established in 2004, is one of its five partnership theme boards. The director of the children and young people's services took up post in April 2005, when the executive member for children and young people was also appointed. The partnership includes the Metropolitan Police, the Haringey Teaching Primary Care Trust (HtPCT), the community and the voluntary sectors, the North London Learning and Skills Council (LSC), and Connexions and the College of North East London (CONEL).

6. The children and young people's plan 'Changing Lives' was published in April 2006 and was reviewed in 2007. The partnership board draws on the views of the wider community through the partnership forum, which meets three times a

year. Its main role is to monitor the progress of the children and young people's plan.

7. The local safeguarding children board (LSCB) was established to help meet the requirement of the 2004 Children Act to 'safeguard and promote the welfare of children'. It brings together the main organisations that work with children and families in the borough, including the Council, Haringey teaching primary care trust and the Metropolitan Police Service.

8. Primary health care for children in Haringey is the responsibility of Haringey teaching primary care trust. Before 1 April 2008, the community paediatricians were managed from Great Ormond Street Hospital. Since 1 April 2008, Haringey teaching primary care trust has commissioned Great Ormond Street Hospital to manage the whole children and young people's health service. North Middlesex University Hospital (NMUH) NHS Trust is the main provider of acute health services, although Great Ormond Street Hospital also runs its acute paediatric service within a partnership unit. The Whittington Hospital NHS Trust also provides services for acute and paediatric care. Children's mental health services are provided by the Barnet, Enfield and Haringey Mental Health NHS Trust. All trusts providing health services for the children of Haringey fall within the NHS London Strategic Health Authority.

9. Haringey has 63 primary (including infant and junior) schools, 10 secondary schools, one city academy, four special schools, a pupil support centre and 17 children's centres. North London Learning and Skills Council works closely with the local authority, the college, training providers, and schools in addressing the 14-19 strategy. Post-16 education and training is provided by College of North East London, and five work-based training providers. Education to Employment provision is managed by the North London consortium, which controls 32 places within Haringey and around 600 places with providers outside Haringey. Adult and community learning including family learning are provided by the local authority.